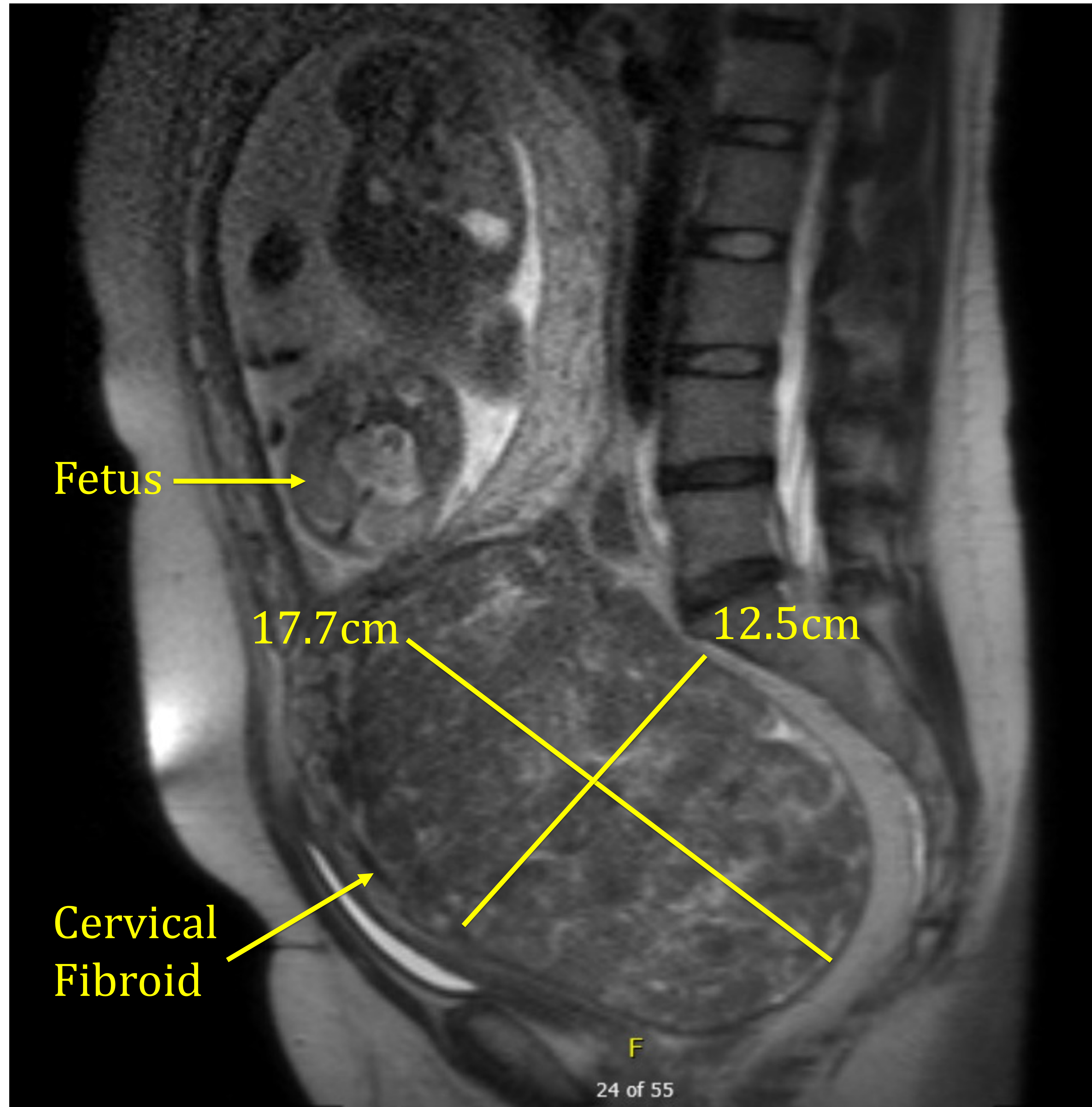


Parturient with Massive Cervical Fibroid Requiring Repeat Cesarean Section



44-year-old G6P3023 at 26w 6d is admitted with PPRM

- **17.7cm x 12.5cm** cervical fibroid obstructing vaginal canal
- **Nephrostomy tubes** due to hydronephrosis
- Prior C/S
- Acutely psychotic upon admission

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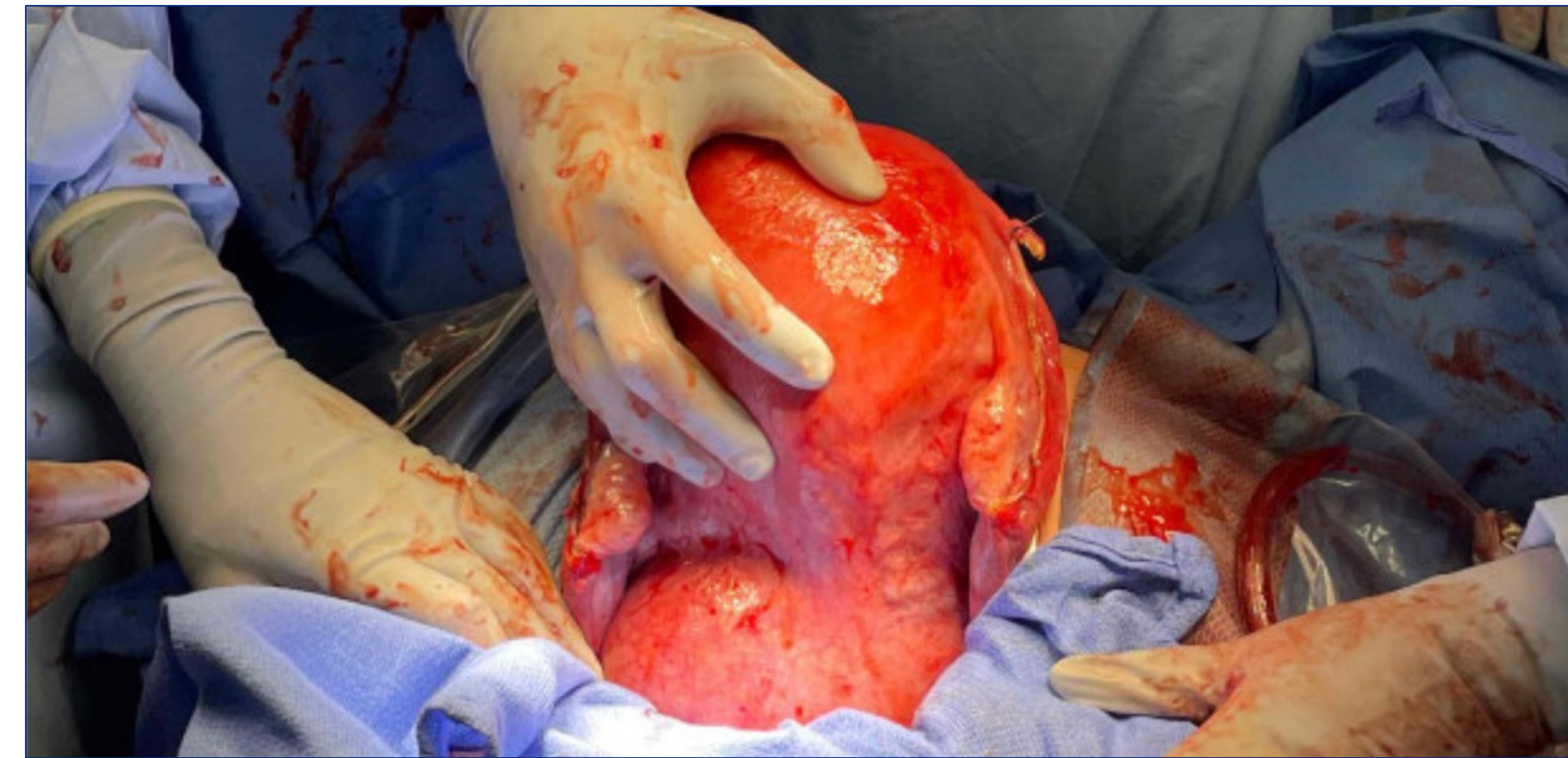
Anesthetic Considerations

Concern	Patient risk factors	Targeted Preparation
Increased risk of hemorrhage	- Altered anatomical layout - Unclear vessels feeding the fibroid - Difficult fetal extraction -- increased blood loss - History of C/S – adhesions - Uterine atony due to fibroid	- Art line for blood pressure monitoring - Type and cross for 4 units of whole blood ready in room - Preparation for possible central line - Uterotonics prepared
Transition from neuraxial to general anesthesia	- Length of procedure - Prior C/S - Giant fibroid - Possible hysterectomy	- Induction medications and airway supplies prepared and accessible - Clear communication with OB and Gyn-Onc teams throughout surgery
Inability to cooperate during procedure	History of schizophrenia, waxing and waning psychosis	- Prolong antipsychotic treatment as long as possible prior to surgery - Sedation medications available intraoperatively - Prepared for emergent GA



Case Progression

1. Multidisciplinary team conference to discuss management plan
2. Acute psychosis treated with olanzapine for 6.5 weeks
3. Patient deemed to have capacity the day of surgery by managing team
4. C/S with tubal ligation in main OR **under epidural with art-line and large-bore IV access**
5. Gyn-Onc consulted to visualize anatomic structures and plan for possible future removal of fibroid
6. Dexmedetomidine 8mcg post-delivery, fibroid not disturbed, hemostasis achieved, EBL ~700ml



Discussion:

- Importance of a multidisciplinary approach & plan
- Unpredictable mental health condition added to the need for a clear plan and communication as the case progressed
- The outcome was optimal, in part due to the **advanced preparation** by all team members for the possibility of major hemorrhage, potential need for conversion to GA, and potential inability to cooperate due to recent psychotic episode

References

- 3
1. Silva H, Tayade S, Makhija N, Chadha A. "Uterine Artery Embolization and Double-J Stenting in a Case of Urinary Retention Due to a Massive Cervical Fibroid: A Case Report." Cureus. 2022, 14(10):e30013. Published 2022 Oct 6.
 2. Sundaram R, Brown AG, Koteeswaran SK et al. "Anaesthetic Implications of Uterine Artery Embolisation in Management of Massive Obstetric Haemorrhage." Obstetric Anesthesia Digest 26(4):202, Dec 2006.